

Clinical microbiological case: penile ulcer and lung infiltrates in a leukemic patient

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CASE REPORT

A 63-year-old man with chronic myeloid leukemia (1994) on maintenance therapy with hydroxyurea was admitted because of 3 days of fever.

He had suffered 2 months of fatigue, malaise, moderate loss of weight, dark urine and holocraneal cephalaea. On

admission, he was conscious, oriented and febrile (38.5 °C). Physical examination disclosed an enlarged, non-painful liver. The white blood cell count $\times 10^3/\text{mm}^3$ was 900 (neutrophils 69%, lymphocytes 30%, bands 3%), the hemoglobin level was 8.5 mg/dL, and the platelet count was 63 000/ mm^3 . Other abnormal laboratory tests included alanine aminotransferase 68 U/L, aspartate aminotransferase 122 U/L, γ -glutamyl



Figure 1 Nosocomial penile ulcer in a leukemic patient.

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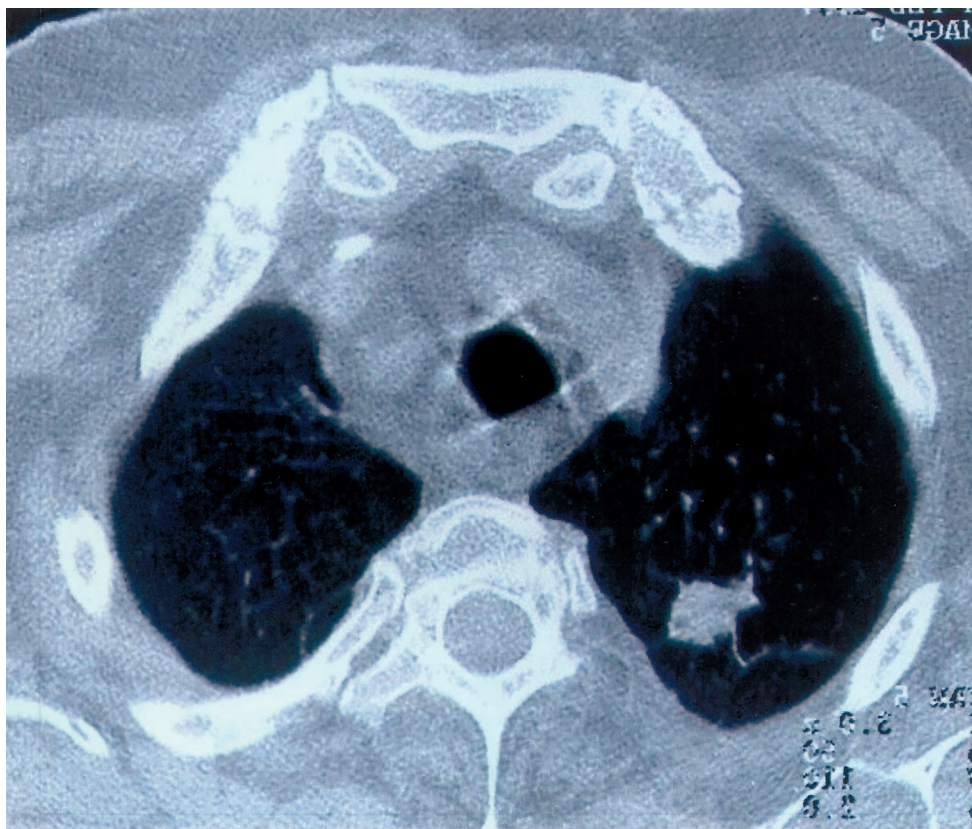


Figure 2 Nodular infiltrate in the lung CTscan.

transpeptidase 269 U/L, alkaline phosphatase 1289 U/L, and bilirubin 3.4 mg/dL.

A cranial CT scan was within normal limits, and a cerebrospinal fluid puncture and a bone marrow biopsy showed leukemic infiltration. A course of intrathecal (methotrexate, ARA-C, actocortin) and intravenous chemotherapy was then initiated. The patient was profoundly neutropenic for 11 days. On day 28, he had a catheter-related bacteremia caused by *Enterococcus faecalis* which finally required removal of the Hickman catheter.

Four weeks after admission, the patient presented a penile ulcer with elevated and indurated borders of about 1 cm

(Figure 1). A thoracic CT scan showed bilateral infiltrates (Figure 2).

QUESTIONS

1. What is your differential diagnosis and what is your preferred diagnostic technique?
2. What are the incidence and clinical and microbiological characteristics of the microorganism that you consider to be probably responsible?
3. What are the therapy and prognosis of this entity?